PART I —1. Full Name (Print) [illegible] (If married woman, show maiden name in parentheses)

Single ☐ Married ☒ Widowed ☐ Divorced ☐ Separated ☐

Mailing Address 3457 East St.

City Montgomery State AL Zip Code 36110

2. Birthplace? State	Birthdate? Mo.	Day	Yr.	Ins. Age?	Sex?	Height? Ft.	In.	Wt.? Lbs.
AL	11	11	40	50	M	6	—	200

3. Employer? Jackson Hos.

Occupation? Maintenance

Duties? Maintenance

4. Social Security Number: 423-48-5696

	Yes	No
5. a. Any past, present, or expected aviation activities	☐	☒
b. Any past, present, or expected rodeo, skin diving, sky diving activities, or racing, testing or stunt driving of automobiles, motorcycles, motor boats, snowmobiles or airplanes? (If yes to a or b above, attach completed questionnaire.)	☐	☒
6. Do you now use alcoholic beverages in any form?	☐	☒
7. Have you ever been treated for alcoholism, drug use, used drugs or alcohol to excess or been arrested for possession, sale or use?	☐	☒
8. a. Do you use tobacco in any form?	☐	☐
b. If prior use, how long since stopped?		
9. Will this policy replace any existing insurance or annuities in force in this or any other company? P. Risk - See Back	☒	☐

10. Insurance Applied For? Life Plan: G.P. Amount $50,000

(If Universal Life, what Death Benefit? Option 1 ☒ or Option 2 ☐)

Term Rider: _____ Amount $_____

Annuity Plan: _____ Amount $_____

Disability Income Plan: _____ Amount $_____

Earned Income: $_____ (For Disability Income Plans Only)

Automatic Premium: Loan (Not UL or Term) ☐ Yes ☐ No

Additional Benefits:	YES	NO		YES	NO
Cost of Living (UL Only)	☒	☐	Family Plan (Not UL)	☐	☒
Waiver of Premium/Deduction	☒	☐	Children's Term	☐	☒
Accidental Death Benefit	☐	☒	Guaranteed Insurability	☐	☒
ADB Amount? _____			Juvenile Payor Benefit	☐	☒

Other Requests? _____

11. Premium quoted? $ 58.00 Amt. Pd.? $ 27.33

ANN ☐ S-A ☐ QTR ☐ PAC ☒ Other ☐ Receipt Issued ☒

12. Beneficiaries? Please print full names		Relationship	Age
First	Jeanette Smith	Wife	49
Contingent	Jan M. Grandalski	Daughter	25
Contingent	Joy L. Campbell	Daughter	22

a. Contingent Beneficiaries share and share alike, survivors or survivor? Yes ☒ No ☐

b. Include future children of present marriage Yes ☐ No ☒

13. Present life and disability insurance		Life	Acci. De...	Mo. Income
Co. and Issue Year	P.R. Risk	$6,000	$	$

NON-MEDICAL LIMITS—(Include face amount of any riders and business in force with Preferred Risk) 15 days to 35 years—$150,000; 36 to 40 years—$100,000; 41 to 45 years—$50,000; 46 to 50 years—$25,000; 51 up needs physical. Is Physical Arranged Yes ☒ No ☐

PART II Has proposed insured:	YES	NO
1. Had medical, surgical or other treatment or advice in past 5 years?	☐	☒
2. Ever had an operation or blood transfusion; or has operation, restricted diet, use of heart, blood pressure or diabetes medication been advised?	☐	☒
3. Ever had, been diagnosed as having, or does proposed insured now have:		
a. Disease or disorder of		
1) Lungs, bronchi; tuberculosis; exposure to tuberculosis; asthma?	☐	☒
2) Heart, blood, blood vessels; high or low blood pressure, murmer?	☐	☒
3) Esophagus, stomach, intestines, liver, gall bladder, rupture?	☐	☒
4) Brain, nervous system; paralysis; convulsions; mental disorder?	☐	☒
5) Back; muscles, bones, joints, limbs; rheumatism; arthritis?	☐	☒
6) Kidneys, ureters, bladder, reproductive organs?	☐	☒
7) Throat, lungs, bronchial tubes, spitting of blood, frequent or persistent cough?	☐	☒
b. If proposed insured is a woman—1) Complications of pregnancy?	☐	☒
2) Is proposed insured pregnant?	☐	☒
c. Cancer, a growth; diabetes; impaired sight, hearing; syphilis?	☒	☐
d. Acquired Immune Deficiency Syndrome, any immune disorder, or related condition?	☐	☒
e. Are you currently taking any prescription medication? (If yes give details)	☐	☒
f. Any other impairment, sickness, injury in past 5 years?	☐	☒
4. A history in parents, brothers or sisters of:		
a. Mental illness, cancer, coronary disease, diabetes, a stroke?	☐	☒
b. Death before age 60? (Relationship? Age? Cause of death?)	☐	☒
5. Ever received sickness or injury benefits, compensation, pension?	☐	☒
6. Ever had insurance refused, postponed, rated or limited?	☐	☒

IF YES, GIVE FULL DETAILS—AILMENTS; DATES; PHYSICIAN'S NAMES, ADDRESSES; OTHER COMPANIES, ETC.

3c- Reading Glasses

PREFERRED RISK

APR 02 1991

LIFE INSURANCE

EXHIBIT 4 ALL-STATE LEGAL®

SM 033

7. Usual physician Philip Robinson

Address 1235 Forest Ave Phone 262-0312

Montgomery, AL

IT IS AGREED: 1) All statements in this application, which includes pages 2 and 3 if applicable, are, so far as I (we) know and believe, complete and true; 2) the Company is not bound by any statement not written in this application; 3) no agent can accept risks, modify policies, or waive any rights or requirements of the Company; 4) unless otherwise provided in a conditional receipt bearing the date of this application, no liability exists until a policy is accepted and the premium paid while, to the best knowledge and belief of the applicant; A) the health and occupations of all persons proposed for health coverage are as described in this application; or B) all persons proposed for coverage under a life policy are still living and in good health.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Preferred Risk Life Insurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be valid as the original. I acknowledge receipt of the Notice To Applicant—parts one and two.

Applicant (owner unless otherwise specified)	Spouse (if Family Plan or Joint Life)	Date Signed
James A. Smith		3/26/91
Proposed Insured (if other than Applicant)	Proposed Payor (if other than Owner)	
Montgomery AL	[illegible] 1-989	

No 219432-O

Use Black Ink DL 1194765 ... APR 09 91 N.H. Do Not Use Dashes, Ditto or Check Marks

PART II OF APPLICATION FOR INSURANCE IN THE PREFERRED RISK LIFE INSURANCE COMPANY

1. Full First Name	Initial	Last Name	Date of Birth Month	Day	Year	Place of Birth	Occupation
James	A	Smith	11	11	40	AL	Maintenance Specialist

Question	Yes	No
2a. Do you now use alcoholic beverages in any form? If "Yes", state kind, and daily, weekly or monthly amount.		X
b. Have you ever been an habitual user of any habit-forming drug, or received treatment for alcoholism or drug habit?		X
3. Have you ever been on a restricted diet or received insulin?		X
4a. Have you gained/lost any weight in past year? lbs. gained lbs. lost Cause		X
b. How long has present weight been maintained? 3 yrs		
5. Have you ever been rejected, deferred or discharged by the Armed Forces because of physical or mental condition?		X
6. Has your application for life, health or accident insurance ever been rejected, rated up, restricted, postponed or withdrawn? If "Yes", give reason and date.		X
7a. Have your parents or any of your brothers or sisters ever had insanity or (diabetes?)	X	
b. Has any person in your immediate household had tuberculosis within the past 5 years?		X

Details of questions 2-7 answered "Yes" above.

9. Have you ever had or been told you had:	Yes	No
a. High blood pressure, pain or pressure in the chest, shortness of breath or palpitation; angina pectoris, heart murmur, coronary, rheumatic fever, or other disease of the heart?		X
b. Stroke, paralysis, epilepsy, insanity, dizziness, convulsions, nervous prostration, severe headaches or any disease of the brain or nervous system?		X
c. Pleurisy, asthma, tuberculosis, spitting of blood, chronic cough, or any disease of the throat, lungs or blood vessels?		X
d. Chronic indigestion, gastric or duodenal ulcer, diabetes, jaundice, chronic diarrhea, gallstones, or any disease of the liver?		X
e. Kidney stones, syphilis, or any disease of the kidneys, bladder or prostate, or albumin or sugar in the urine?		X
f. Enlarged glands, goiter, cancer or any tumor, gout, rheumatism, any disease of the skin, bones or joints; any defect of hearing or eyesight?		X
g. Acquired Immune Deficiency Syndrome, any immune disorder, or related condition?		X
10a. Have you ever been in any hospital or sanitarium for rest, treatment, observation, diagnosis, or surgery?		X
b. Within the past five years have you undergone any special examinations or laboratory tests, such as X-rays, electrocardiograms, blood or urine tests?	X	

Give name of disease or symptoms, number of attacks, dates, duration, severity and results, and attending physicians' names and addresses.

10b. receives annual physical including B/P, U/A, routine blood tests, EKG, X-ray, all results normal for employment. Jackson Hospital 1235 Forest Ave Montgomery, AL

7a. Mother now age 71 has insulin controlled diabetes age 50 onset

PREFERRED RISK APR 08 1991 LIFE INSURANCE

SM 034

11a. Have you consulted or been examined by any other physicians or practitioners within the last 5 years? Yes or (No)

NAME AND ADDRESS	REASON FOR CONSULTATION, EXAMINATION OR TREATMENT	DATE, DURATION AND RESULT

11b. Name of regular personal physician: Dr. Phillip Robinson Address: 1727 Pine Montgomery, AL

12. Have you had any illness or injury not mentioned above? If "None", so state. None

13. Family Record	Age if Living	State of Health	Age at Death	Cause of Death
Father			68	Cancer of colon
Mother	71	fair		
(1) Brothers No. Living 0 No. Dead 1			3 months	Poisoned castor oil
(4) Sisters No. Living 4 No. Dead 0	57, 43, 38, 34	good		

14. To be completed if proposed insured is a woman.
a. Full Maiden Name?
b. No. and character of labors?
c. Date of last labor?
d. Are you now pregnant? No. of months?
e. Have you passed the change of life?
f. Have you ever had any uterine, ovarian or breast disease, menstrual disorder, abortion or miscarriage?

I state that I am the person named as the proposed insured or the applicant in juvenile cases, and I declare and agree that the foregoing statements and answers and those contained in Part I of this application, each of which I have made and read, are complete, true and correctly recorded to the best of my knowledge and belief, and shall form the basis for and shall be a part of this contract of insurance.

I hereby authorize any licensed physician, medical practitioner, hospital, or other medically related facility, insurance company or other organization, institution or person, that has any information of me or my health, to give to Preferred Risk Life Insurance Company any such information. A photographic copy of this authorization shall be as valid as the original.

Dated at Montgomery, AL, this 2nd day of April, 19 91

Witnessed by Nancy R. Schofield L.A. APPLICANT (for Child Policy) or James A. Smith PROPOSED INSURED

L-5002B (786)

PART I —1. Full Name (Print) Jeanette H. Smith
(If married woman show maiden name in parentheses)

Single ☐ Married ☒ Widowed ☐ Divorced ☐ Separated ☐

Mailing Address 3451 East St.

City Montgomery State Al Zip Code 36110

2. Birthplace? State	Birthdate? Mo.	Day	Yr.	Ins. Age?	Sex?	Height? Ft.	In.	Wt.? Lbs.
Al	10	11	41	49	F	5	9	170

3. Employer? St. of Al.
Occupation? Auditor
Duties?
4. Social Security Number: 417-56-6746

	Yes	No
5 a. Any past, present, or expected aviation activities	☐	☒
b. Any past, present, or expected rodeo, skin diving, sky diving activities, or racing, testing or stunt driving of automobiles, motorcycles, motor boats, snowmobiles or airplanes? (If yes to a or b above, attach completed questionnaire.)	☐	☒
6. Do you now use alcoholic beverages in any form?	☐	☒
7. Have you ever been treated for alcoholism, drug use, used drugs or alcohol to excess or been arrested for possession, sale or use?	☐	☒
8. a. Do you use tobacco in any form?	☐	☒
b. If prior use, how long since stopped?		
9. Will this policy replace any existing insurance or annuities in force in this or any other company?	☐	☒

10. Insurance Applied For? Life Plan: U.L. Amount $ 20000
(If Universal Life, what Death Benefit? Option 1 ☒ or Option 2 ☐)
Term Rider: Amount $
Annuity Plan: Amount $
Disability Income Plan: Amount $
Earned Income: $ (For Disability Income Plans Only)
Automatic Premium Loan (Not UL or Term) ☐ Yes ☐ No

Additional Benefits:	YES	NO		YES	NO
Cost of Living (UL Only)	☒	☐	Family Plan (Not UL)	☐	☒
Waiver of Premium/Deduction	☒	☐	Children's Term	☐	☒
Accidental Death Benefit	☒	☐	Guaranteed Insurability	☐	☒
ADB Amount?			Juvenile Payor Benefit	☐	☒

Other Requests?
11. Premium quoted? $ 31.00 Amt. Pd.? $ 31.00
ANN ☐ S-A ☐ QTR ☐ PAC ☒ Other ☐ Receipt Issued ☒

12. Beneficiaries?	Please print full names	Relationship	Age
First	James A. Smith	Husband	50
Contingent	Jan M. Grandalski	Daughter	25
	Joy L. Campbell	Daughter	22

a. Contingent Beneficiaries share and share alike. survivors or survivor? Yes ☒ No ☐
b. Include future children of present marriage Yes ☐ No ☒

13. Present life and disability insurance	Life	Acci. Death	Mo. Income
Co. and Issue Year	Mut. J.W.L. $10,000	$	$

NON-MEDICAL LIMITS—(Include face amount of any riders and business in force with Preferred Risk) 15 days to 35 years—$150,000; 36 to 40 years—$100,000; 41 to 45 years—$50,000; 46 to 50 years—$25,000; 51 up needs physical. Is Physical Arranged Yes ☒ No ☐

PART II Has proposed insured:	YES	NO
1. Had medical, surgical or other treatment or advice in past 5 years?	☐	☒
2. Ever had an operation or blood transfusion; or has operation, restricted diet, use of heart, blood pressure or diabetes medication been advised?	☒	☐
3. Ever had, been diagnosed as having, or does proposed insured now have:		
a. Disease or disorder of		
1) Lungs, bronchi; tuberculosis; exposure to tuberculosis; asthma?	☐	☒
2) Heart, blood, blood vessels; high or low blood pressure, murmer?	☐	☒
3) Esophagus, stomach, intestines, liver, gall bladder, rupture?	☐	☒
4) Brain, nervous system; paralysis; convulsions; mental disorder?	☐	☒
5) Back; muscles, bones, joints, limbs; rheumatism; arthritis?	☐	☒
6) Kidneys, ureters, bladder, reproductive organs?	☒	☐
7) Throat, lungs, bronchial tubes, spitting of blood, frequent or persistent cough?	☐	☒
b. If proposed insured is a woman—1) Complications of pregnancy?	☐	☒
2) Is proposed insured pregnant?	☐	☒
c. Cancer; a growth; diabetes; impaired sight, hearing; syphilis?	☒	☐
d. Acquired Immune Deficiency Syndrome, any immune disorder, or related condition?	☐	☒
e. Are you currently taking any prescription medication? (If yes give details)	☐	☒
f. Any other impairment, sickness, injury in past 5 years?	☐	☒
4. A history in parents, brothers or sisters of:		
a. Mental illness, cancer, coronary disease, diabetes, a stroke?	☐	☒
b. Death before age 60? (Relationship? Age? Cause of death?)	☐	☒
5. Ever received sickness or injury benefits, compensation, pension?	☐	☒
6. Ever had insurance refused, postponed, rated or limited?	☐	☒

YES, GIVE FULL DETAILS—AILMENTS; DATES; PHYSICIAN'S NAMES, ADDRESSES; OTHER COMPANIES, ETC.

2. – Malignant Pol. – Removed From Colon 10/1984
– Baptist Hos. S. Blvd Mtg, Al
– Dr David Dunn Baptist Towers Mtg, Al.
1979 – Hysterectomy – Dr. David Dunn
3.c. – Impaired Sight
– Premarin? – Hormone .625 MG 25.00 charge

PREFERRED RISK
APR 02 1991
LIFE INSURANCE

7. Usual physician Dr. David Dunn
Address 2055 E. East South Blvd Baptist Towers Phone 288-3315
Mtg, Al.

IT IS AGREED: 1) All statements in this application, which includes pages 2 and 3 if applicable, are, so far as I (we) know and believe, complete and true; 2) the Company is not bound by any statement not written in this application; 3) no agent can accept risks, modify policies, or waive any rights or requirements of the Company; 4) unless otherwise provided in a conditional receipt bearing the date of this application, no liability exists until a policy is accepted and the premium paid while, to the best knowledge and belief of the applicant; A) the health and occupations of all persons proposed for health coverage are as described in this application; or B) all persons proposed for coverage under a life policy are still living and in good health.
I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Preferred Risk Life Insurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be valid as the original. I acknowledge receipt of the Notice To Applicant—parts one and two.

X Jeanette H. Smith — Applicant (owner unless otherwise specified)
Spouse (if Family Plan or Joint Life)
3/26/91 — Date Signed
Montgomery, Al. — Proposed Insured (if other than Applicant)
Proposed Payor (if other than Owner)
Soliciting Agent Code
No 219433 – Q

Questions which must be answered by proposed insured and recorded by medical examiner with the ... present

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PART II OF APPLICATION FOR INSURANCE IN THE PREFERRED RISK LIFE INSURANCE COMPANY

1. Full First Name	Initial	Last Name	Date of Birth Month	Day	Year	Place of Birth	Occupation
Jeanette	H	Smith	10	11	41	al	auditor

Question	YES	NO
2a. Do you now use alcoholic beverages in any form? If "Yes", state kind, and daily, weekly or monthly amount.		X
b. Have you ever been an habitual user of any habit-forming drug, or received treatment for alcoholism or drug habit?		X
3. Have you ever been on a restricted diet or received insulin?		X
4a. Have you gained/lost any weight in past year? lbs. gained 20 lbs. lost Cause lack of exercise	X	
b. How long has present weight been maintained? 1 yr		
5. Have you ever been rejected, deferred or discharged by the Armed Forces because of physical or mental condition?		X
6. Has your application for life, health or accident insurance ever been rejected, rated up, restricted, postponed or withdrawn? If "Yes", give reason and date.		X
7a. Have your parents or any of your brothers or sisters ever had insanity or diabetes?		X
b. Has any person in your immediate household had tuberculosis within the past 5 years?		X

Details of questions 2-7 answered "Yes" above.

9. Have you ever had or been told you had:	YES	NO
a. High blood pressure, pain or pressure in the chest, shortness of breath or palpitation, angina pectoris, heart murmur, coronary, rheumatic fever, or other disease of the heart?		X
b. Stroke, paralysis, epilepsy, insanity, dizziness, convulsions, nervous prostration, severe headaches or any disease of the brain or nervous system?		X
c. Pleurisy, asthma, tuberculosis, spitting of blood, chronic cough, or any disease of the throat, lungs or blood vessels?		X
d. Chronic indigestion, gastric or duodenal ulcer, diabetes, jaundice, chronic diarrhea, gallstones, or any disease of the liver?		X
e. Kidney stones, syphilis, or any disease of the kidneys, bladder or prostate, or albumin or sugar in the urine?		X
f. Enlarged glands, goiter, cancer or any tumor, gout, rheumatism, any disease of the skin, bones or joints; any defect of hearing or eyesight?	X	
g. Acquired Immune Deficiency Syndrome, any immune disorder, or related condition?		X
10a. Have you ever been in any hospital or sanitarium for rest, treatment, observation, diagnosis, or surgery?		X
b. Within the past five years have you undergone any special examinations or laboratory tests, such as X-rays, electrocardiograms, blood or urine tests?	X	

Give name of disease or symptoms, number of attacks, dates, duration, severity and results, and attending physicians' names and addresses.

9f. 1984 Hospitalized 2 weeks due to malign polyp of colon. Normal recovery, no further problems. Has annual recheck Dr. David Dunn Baptist Medical Ctr Baptist Medical Tower 2105 E.S. Blvd. Montgomery, Al Montgomery, Al

10b. Has yearly barium enema, colonoscopy, routine blood tests, B/P, U/A, all results normal. See dr. 9f above

14f. 1979 Hospitalized 7 days due to hysterec due to endometriosis. No further problems. See dr. 9f above. Humana Hospital Taylor Rd Montgomery, Al

11a. Have you consulted or been examined by any other physicians or practitioners within the last 5 years? (Yes) or No

NAME AND ADDRESS	REASON FOR CONSULTATION, EXAMINATION OR TREATMENT	DATE, DURATION AND RESULT
Dr. James McLaughlin 1237 Pine Montgomery, Al	Cold symptoms for about 6 weeks, took antibiotic for 1 week, 10 days decongestant, no further problems	Oct 1990 & Oct 1989

11b. Name of regular personal physician: see 9f. Address:

12. Have you had any illness or injury not mentioned above? If "None", so state. NO

13. Family Record	Age if Living	State of Health	Age at Death	Cause of Death
Father	69	poor		
Mother	69	good		
(2) Brothers No. Living 2 No. Dead 0	44 / 47	good		
0 Sisters No. Living 0 No. Dead 0				

PREFERRED RISK APR 08 1991 LIFE INSURANCE

14. To be completed if proposed insured is a woman.
a. Full Maiden Name? Iris Jeanette Holladay
b. No. and character of labors? 2 full term
c. Date of last labor? Feb 1969
d. Are you now pregnant? NO No. of months?
e. Have you passed the change of life? In process
f. Have you ever had any uterine, ovarian or breast disease, menstrual disorder, abortion or miscarriage? See above

I state that I am the person named as the proposed insured or the applicant in juvenile cases, and I declare and agree that the foregoing statements and answers and those contained in Part I of this application, each of which I have made and read, are complete, true and correctly recorded to the best of my knowledge and belief, and shall form the basis for and shall be a part of this contract of insurance. I hereby authorize any licensed physician, medical practitioner, hospital, or other medically related facility, insurance company or other organization, institution or person, that has any information of me or my health, to give to Preferred Risk Life Insurance Company any such information. A photographic copy of this authorization shall be as valid as the original.

Dated at Montgomery, Al this 2nd day of April, 19 91

Witnessed by Nancy P. [illegible], L.A. M.D.

APPLICANT (for Child Policy) or Jeanette H. Smith PROPOSED INSURED

L-5002B (786)